

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-038554**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 161

**FILED SEP 25 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Saline</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Saline County Rest Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> c. CITY OR TOWN <u>Marshall</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>631 E Thomas</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>James Alfred Sawyer</u>		<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>14</u> Year <u>1963</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-18-1886</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Automotive</u>	
<b>11a. FATHER'S NAME</b> <u>Edward Sawyer</u>		<b>11b. MOTHER'S MAIDEN NAME</b> <u>Mattie Fields</u>	
<b>12a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		<b>12b. SOCIAL SECURITY NO.</b> <u>15</u>	
<b>13. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Syphilitic (disease)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>(Panyletic)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Anna Belle Lee</u> <b>15. INFORMANT</b> <u>Thelma Wilburn Marshall, Mo</u> Address _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 Mems.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <u>May 1st 1963</u> <b>to</b> <u>Sept. 14 1963</u> <b>and last saw her</b> <u>Sept. 14 1963</u> <b>alive on</b> _____ <b>Death occurred at</b> <u>5-12-63</u> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>			
<b>22a. SIGNATURE</b> (Degree or title) <u>C. L. Lawless M.D.</u>		<b>22b. ADDRESS</b> <u>Marshall Mo</u>	
<b>22c. DATE SIGNED</b> <u>9-17-63</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIED</u>	
<b>23b. DATE</b> <u>Sept. 19-1963</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cemetery Marshall</u>	
<b>23d. LOCATION</b> (City, town, or county) <u>Mo.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Geo. H. Green</u> <b>ADDRESS</b> <u>Fulton, Mo.</u>	
<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-15-63</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Cecil D. Read</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300  
Rev. 4/59

1 0970

2 0975

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12 86-5

13 3-0

SEP 26 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by CHARLES RICHARD WILLIAMS, Student Embalmer No. 693  
working under my personal supervision.

Student Charles R. Williams  
Signature of Student Embalmer

Signed Georgette H. Green

Licensed Embalmer No. 4220

P. O. Address Fulton, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.